Key Practices	WHO Recommendations	Evidence	References
Early skin-to-skin contact between mother and newborn – term and preterm babies **Immediate and thorough drying and stimulation** **Maintain a "warm chain" for every newborn**	Newborns without complications should be kept in skin-to-skin contact with their mothers during the first hour- 90 minutes after birth to prevent hypothermia and promote breastfeeding. Low-birth-weight neonates weighing >1200 g who do not have complications and are clinically stable should be put in skin-to-skin contact with the mother soon after birth and after drying them thoroughly to prevent neonatal hypothermia. Maintain the "warm chain": 1) warm delivery room; 2) immediate drying; 3) skin-to-skin contact: 4) early breastfeeding; 5) bathing and weighing postponed; 6) appropriate clothing/bedding; 7) mother and baby together; 8) warm transportation; 9) warm resuscitation.	*Immediate or early SSC for healthy newborns <u>vs</u> separation or limited contact (ref 2 and refs 16-18)* ➢ 25% increased BF at one and four months ➢ 64 days longer BF duration ➢ 30% increased Exclusive BF ➢ 32% increased first BF successful ➢ Increased stability of the cardio-respiratory system ➢ Increased blood glucose level ➢ Better interaction mother-baby ➢ Less baby crying *Duration of STS contact*: Average timing of first BF is 55 minutes. A proportion do not feed until after the first hour. Any separation reduces the likelihood of effective breastfeeding (ref 3). SSC with CS: Significantly increases EBF rates, decreases neonatal morbidity, decreases NCU admission rates, decreases formula use rates *Hypothermia*. Three thermal care practices (delayed bathing, head covering, and skin-to-skin care) - 20% reduction in preterm deaths and 10% reduction in full-term or moderately preterm infection deaths. Also, reductions in respiratory illness, hypoglycaemia (ref 4, 5, 6, 13).	1. WHO recommendations on newborn health: guidelines approved by the WHO Guidelines Review Committee. Geneva: World Health Organization; 2017 (WHO/MCA/17.07). Licence: CC BY-NC-SA 3.0 IGO. 2. Moore ER, Bergman N, Anderson GC, Medley N. Early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database of Systematic Reviews 2016, Issue 11. Art. No.: CD003519. DOI: 10.1002/14651858.CD003519. pub4. 3. Righard L, Alade M.O. Effect of delivery room routines on success of first breastfeed. The Lancet 1990; 336: 1105-7 4. WHO. Thermal protection of the newborn: a practical guide. Maternal and Newborn Health/Safe Motherhood Unit, Division of Reproductive Health. WHO: Geneva, 1997. 5. K Lunze and DH Hamer Journal of Perinatology (2012) 32, 317–324. Thermal protection of the newborn in resource-limited environments. 6. Zulfi qar A Bhutta, Jai K Das, Rajiv Bahl, Joy E Lawn, Rehana A Salam, Vinod K Paul, et al. Can available interventions end preventable deaths in mothers, newborn

Key Practices	WHO Recommendations	Evidence	References
			babies, and stillbirths, and at what cost? Lancet 2014; 384: 347–70
Delayed cord clamping	Late cord clamping (performed after 1 to 3 minutes after birth) is recommended for all births *(term and preterm)* while initiating simultaneous essential newborn care. Early cord clamping (< 1 minute after birth) is not recommended unless the neonate is asphyxiated and needs to be moved immediately for resuscitation.	*Late <u>vs</u> early cord clamping, all infants:* (ref 8) ➢ Increased early hemoglobin concentration ➢ Increased iron stores at 3-6 months ➢ No higher risk of PP hemorrhage ➢ Increased (but very small) risk of need of phototherapy for jaundice *Late <u>vs</u> early cord clamping, in **preterm** infants (24-36 w)* (ref 9)*:* ➢ 61% reduced need of transfusion for anaemia ➢ 41% reduction intraventricular hemorrhage ➢ 38% lower necrotizing Enterocolitis *No evidence that holding the infant at birth at the level of the vagina or below* has any benefit for baby compared to placing the baby directly onto the mother's chest (ref 11)	7. WHO recommendations on newborn health: guidelines approved by the WHO Guidelines Review Committee. Geneva: World Health Organization; 2017 (WHO/MCA/17.07). Licence: CC BY-NC-SA 3.0 IGO. 8. McDonald SJ, Middleton P, Dowswell T, Morris PS. Effect of timing of umbilical cord clamping of term infants on maternal and neonatal outcomes. Cochrane Database of Systematic Reviews 2013, Issue 7. Art. No.: CD004074. DOI:10.1002/14651858.CD004074.pub3 9. Rabe H, Diaz-Rossello JL, Duley L, Dowswell T. Effect of timing of umbilical cord clamping and other strategies to influence placental transfusion at preterm birth on maternal and infant outcomes. Cochrane Database of Systematic Reviews 2012, Issue 8. Art. No.: CD003248. DOI:10.1002/ 14651858.CD003248.pub3 10. Delayed umbilical cord clamping after birth. Committee Opinion No. 684. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;129:e5-10

Key Practices	WHO Recommendations	Evidence	References
			11. Vain, NE, Satragno DS, Gorenstein AN, Gordillo JE,et al. Effect of gravity on volume of placental transfusion: a multicentre, randomized, non-inferiority trial. Lancet 2014 384: 9939: 235-40.
No routine suctioning of newborns	Routine nasal or oral suction should not be done for babies born through clear amniotic fluid who start breathing on their own after birth. In neonates born through clear amniotic fluid who do not start breathing after thorough drying and rubbing the back 2–3 times, suctioning of the mouth and nose should not be done routinely before initiating positive-pressure ventilation. Intrapartum suction of mouth and nose at the delivery of head in neonates born through meconium is not recommended. Suctioning of mouth or nose and tracheal suctioning is not recommended in neonates born through liquor with	*Rubbing the back 2-3 times as well as thorough drying*. No human studies show any benefit to additional tactile stimulation in addition to immediate early drying in non-breathing neonates (ref 12). *Suctioning of the mouth and nose <u>vs</u> no suctioning* (ref 12, 13, 14) ➢ In normal healthy neonates, routine oral and nasal suctioning immediately after birth is associated with lower oxygen saturation levels and lower Apgar scores – and has no impact on neonatal outcomes (ref 12) ➢ In vigorous infants born through meconium - intrapartum suctioning and routine intubation and suctioning do not reduce rates of meconium aspiration syndrome (MAS) or impact neonatal outcomes (ref 13) ➢ In non-vigorous infants born through meconium stained liquor, suctioning of mouth and nose is recommended, but there are no good data to support this practice. ➢ In non-vigorous infants born through meconium - no evidence that	12. WHO recommendations on newborn health: guidelines approved by the WHO Guidelines Review Committee. Geneva: World Health Organization; 2017 (WHO/MCA/17.07). Licence: CC BY-NC-SA 3.0 IGO. 13. Jonathan Wyllie, Jos Bruinenberg, Charles Christoph Roehr, Mario Rüdiger , Daniele Trevisanutoc, Berndt Urlesberger. European Resuscitation Council Guidelines for Resuscitation 2015 Section 7. Resuscitation and support of transition of babies at birth. Resuscitation 95 (2015) 249–263 14. Foster JP, Dawson JA, Davis PG, Dahlen HG. Routine oro/nasopharyngeal suction versus no suction at birth. Cochrane Database of Systematic Reviews 2017, Issue 4. Art. No.: CD010332. DOI: 10.1002/14651858.CD010332.pub2.

Key Practices	WHO Recommendations	Evidence	References
	meconium who start breathing on their own. Suctioning of mouth and nose *is* recommended for babies born through meconium who are not breathing	*intubation and tracheal aspiration* improves mortality outcome or rates of MAS (ref 13) (should only be considered if airway obstruction is likely – otherwise initiate PPV as quickly as possible.)	
Early Breastfeeding	All newborns, including low-birth-weight babies who are able to breastfeed, should be put to the breast as soon as possible after birth when they are clinically stable, and the mother and baby are ready. See: Recommendations on early and prolonged skin-to-skin contact at birth which increase the likelihood of early and exclusive breastfeeding. *Exclusive breastfeeding – HIV positive mothers* Dependent on national feeding guidelines (20) and hospital policy and individual circumstances: - BF and ARV therapy - No breastfeeding and replacement feeding	➢ Initiating BF after the first hour up to doubles the risk of neonatal mortality. ➢ Exclusively breastfed neonates have a lower risk of mortality and infection-related deaths in the first month than partially breastfed neonates. ➢ Exclusively breastfed neonates have a significantly lower risk of sepsis, diarrhea and respiratory infections compared with those partially breastfed. *Late (after the first hour: 2-23 hours or 24-96 hours) vs Early (within the 1st hour):* ➢ 40 or 80% higher mortality during the first month (Ref 16, Ghana, India & Tanzania) ➢ Increased risk of not being exclusively breastfed, and not being breastfed at all at 1 month and 3 months of age (ref 16) *Partial <u>vs</u> Exclusive breastfeeding at 1 month:* ➢ 83% higher mortality during the first 6 months of life (ref 16)	15. WHO recommendations on newborn health: guidelines approved by the WHO Guidelines Review Committee. Geneva: World Health Organization; 2017 (WHO/MCA/17.07). License: CC BY-NC-SA 3.0 IGO. 16. NEOVITA Study Group. Timing of initiation, patterns of breastfeeding, and infant survival: prospective analysis of pooled data from three randomized trials. Lancet Glob Health 2016; 4: e266–75 17. Khan J, Vesel L, Bahl R, Martines JC. Timing of breastfeeding initiation and exclusivity of breastfeeding during the first month of life: effects on neonatal mortality and morbidity – a systematic review and meta-analysis. Matern Child Health J. 2015;19(3):468-79. 18. Balogun OO, O'Sullivan EJ, McFadden A, Ota E, Gavine A, Garner CD, Renfrew MJ, MacGillivray S. Interventions for promoting the initiation of breastfeeding. Cochrane Database of Systematic Reviews 2016, Issue

Key Practices	WHO Recommendations	Evidence	References
	This decision should consider: (19,20) – socio-economic and cultural contexts of the populations served by maternal and child health services; – availability and quality of health services; – local epidemiology including HIV prevalence among pregnant women; and, – main causes of maternal and child under- nutrition and infant and child mortality. Under 6-months: If BF is stopped – scale-down in the first month of life, options: - Commercial formula (provided standards are met – ref 19) - Expressed heat treated breastmilk *Exclusive breastfeeding for women who are Hepatitis B* Positive All infants born to HBV-infected mothers should receive hepatitis B immune globulin (HBIG) and the first dose of hepatitis B vaccine	➢ 381% higher mortality during the first month (ref 17) *No breastfeeding vs. Exclusive breastfeeding at 1 month:* **10 times higher mortality** during the first 6 months of life (ref 16) The risk of HBV mother-to-child transmission through breastfeeding is negligible if infants born to HBV-positive mothers receive the HBIG/HBV vaccine at birth. There is no evidence that HCV can be transmitted through breastfeeding. It is not known for certain whether Hepatitis B or C can be transmitted through cracked and bleeding nipples (21)	11. Art. No.: CD001688. DOI: 10.1002/14651858.CD001688.pub3 19. WHO, UNAIDS, UNFPA, UNICEF. Guidelines on HIV and infant feeding. 2010. Principles and recommendations for infant feeding in the context of HIV and a summary of evidence. Geneva: World Health Organization; 2010 ISBN 978 92 4 159953 5 20. MOH Vietnam. Infant and young child feeding. Manual for health workers on maternal and child care at all levels (trainees handbook). MOH: Hanoi. January 2015 21. WHO Update No. 22, November 1996. Hepatitis B and breastfeeding. WHO, Geneva.

Key Practices	WHO Recommendations	Evidence	References
	within 12 hours of birth – and breastfeed normally. All infants born to HCV positive mothers should breastfeed normally If the HBV-and HVC-positive mother's nipples and/or surrounding areola are cracked and bleeding, she should stop nursing temporarily. To maintain her milk supply while not breastfeeding, she can express and discard her breast milk until her nipples are healed. Once her nipples are no longer cracked or bleeding, the HBV and HVC -positive mother may fully resume breastfeeding.		
Newborn resuscitation	When newly-born term or preterm babies require positive-pressure ventilation, the cord should be clamped and cut to immediately allow effective ventilation to be performed. Newly-born babies who do not breathe spontaneously after	*Early <u>vs</u> late cord clamping in depressed neonates requiring PPV* ➢ Studies on DCC have not included newborns requiring ventilation. ➢ Experts agreed that efforts should focus on early initiation of PPV – with immediate cord clamping (ref 22,23)	22. WHO recommendations on newborn health: guidelines approved by the WHO Guidelines Review Committee. Geneva: World Health Organization; 2017 (WHO/MCA/17.07). Licence: CC BY-NC-SA 3.0 IGO.

Key Practices	WHO Recommendations	Evidence	References
	thorough drying should be stimulated by rubbing the back 2–3 times before clamping the cord and initiating positive-pressure ventilation. In newly-born babies who do not start breathing despite thorough drying and additional stimulation, positive-pressure ventilation should be initiated within one minute after birth. In newly-born term or preterm (>32 weeks gestation) babies requiring positive pressure ventilation, ventilation should be initiated with air. For preterm babies born at or before 32 weeks gestation, it is preferable to start ventilation with 30% rather than 100% oxygen. If this is not possible, ventilation should be started with air. In newly-born babies requiring positive-pressure ventilation, ventilation should be provided	➢ Drying the baby usually produces enough stimulation to induce effective breathing (ref 24, 25) ➢ **Drying and stimulation alone**, is related with a 10% reduction (Range 0-25%, IQR 5-15%) in term intrapartum-related deaths and a 10% reduction (Range 0-20%, IQR 5-10%) in preterm deaths. ➢ **Golden minute**: Evidence around the world show that the risk of death increases by 16% for every 30 s delay in initiating ventilation up to six minutes and every 6% for every minute of delay of applied bag and mask ventilation (ref 23a) ➢ Resuscitation using air reduces the risk of mortality and the time of onset of spontaneous breathing in **neonates born after 32 weeks gestation** when compared with resuscitation using 100% oxygen (ref 24, 25) ➢ Available evidence suggests that the majority **of preterm babies <32 weeks gestation** may be stabilized with resuscitation using air (ref 22, 23) ➢ However, a proportion of these infants need resuscitation with higher	23. WHO Guidelines on Basic Newborn Resuscitation, 2012 24. Jonathan Wyllie, Jos Bruinenberg, Charles Christoph Roehr, Mario Rüdiger , Daniele Trevisanutoc, Berndt Urlesberger. European Resuscitation Council Guidelines for Resuscitation 2015 Section 7. Resuscitation and support of transition of babies at birth. Resuscitation 95 (2015) 249–263 23a. Lee ACC, Cousens S, Wall SN, et al. Neonatal resuscitation and immediate newborn assessment and stimulation for the prevention of neonatal deaths: a systematic review, meta-analysis and Delphi estimation of mortality effect. BMC Public Health 2011;11 Suppl 3(Suppl 3):S12. 25. Jeffrey M. Perlman, Co-Chair*; Jonathan Wyllie, Co-Chair*; John Kattwinkel; Myra H. Wyckoff; Khalid Aziz; Ruth Guinsburg et al. Part 7: Neonatal Resuscitation 2015 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. Circulation. 2015;132 [suppl 1]: S204–S241. DOI: 10.1161/ CIR.0000000000000276.)

Key Practices	WHO Recommendations	Evidence	References
	using a self-inflating bag and mask. In newly-born babies requiring positive-pressure ventilation, ventilation should be initiated using a face-mask interface. In newly-born babies requiring positive-pressure ventilation, adequacy of ventilation should be assessed by measurement of the heart rate after 60 seconds of ventilation with visible chest movements. In newly-born babies who do not start breathing within one minute after birth, priority should be given to providing adequate ventilation rather than to chest compressions.	oxygen concentrations. It appears that the outcome is better if resuscitation is initiated with 30% rather than 90% oxygen (ref 24,25)	25a. Ersdal HL, Mduma E, Svensen E, Perlman JM. Early initiation of basic resuscitation interventions including face mask ventilation may reduce birth asphyxia related mortality in low-income countries. Resuscitation 2012;83(7):869–73.

Key Practices	WHO Recommendations	Evidence	References
Kangaroo Mother Care	Low-birth-weight neonates weighing < 2000 g who are clinically stable should be provided Kangaroo Mother Care beginning early in the first week of life.	*Continuous KMC vs conventional neonatal care* 21 RCTs (3042 infants) (ref 26) <u>*At discharge or 40 to 41 weeks'*</u> ➢ 40% lower mortality ➢ 44% lower nosocomial infection/sepsis ➢ 66% lower hypothermia ➢ 20% increases exclusive breastfeeding <u>At latest follow-up</u> ➢ 37% lower mortality ➢ 50% decreased risk of severe infection/sepsis ➢ increased weight, length and head circumference gain ➢ Increased exclusive breastfeeding at discharge or 40 to 41 weeks' and at one to three months' follow-up ➢ improved mother-infant attachment and home environment Mortality reduction is noted only for continuous KMC (*at least 20 hours in each 24-hour period) initiated within the first 10 days. Beginning within the first 24 hours has benefits over delaying until after the first 24 hours.*	26. Conde-Agudelo A, Díaz-Rossello JL. Kangaroo mother care to reduce morbidity and mortality in low birthweight infants. Cochrane Database of Systematic Reviews 2016, Issue 8. Art. No.: CD002771. DOI:10.1002/14651858.CD002771.pub4.

Key Practices	WHO Recommendations	Evidence	References
Vitamin K	All newborns should be given 1 mg of vitamin K intramuscularly [IM] after birth [after the first hour during which the infant should be in skin-to-skin contact with the mother and breastfeeding should be initiated]. Neonates requiring surgical procedures, those with birth trauma, preterm newborns, and those exposed in utero to maternal medication known to interfere with vitamin K are at especially high risk of bleeding and must be given vitamin K [1 mg IM].	➢ Vitamin K prophylaxis significantly reduces the risk of bleeding in neonates.	27. WHO recommendations on newborn health approved or under review by the WHO Guidelines Review Committee 2013 WHO. Page 3 28. NHMRC (Australian National Health and Medical Research Council) (2010). Joint statement and recommendations on Vitamin K administration to newborn infants to prevent vitamin K deficiency bleeding in infancy – October 2010 (the Joint Statement). 29. D McMillan; Canadian Paediatric Society Fetus and Newborn Committee. Routine administration of vitamin K to newborns: A joint position statement with the College of Family Physicians of Canada. Paediatr Child Health 1997;2(6):429-31

Key Practices	WHO Recommendations	Evidence	References
Newborn immunizations	All infants should receive their first dose of hepatitis B vaccine as soon as possible after birth, preferably within 24 hours. This is crucial in areas of high hepatitis B endemicity, but important even in intermediate and low endemicity areas. Oral polio vaccine, including a birth dose (known as zero dose because it does not count towards the primary series), is recommended in all polio-endemic countries and in countries at high risk for importation and subsequent spread. The birth dose should be administered at birth, or as soon as possible after birth. In settings where tuberculosis is highly endemic or in settings where there is high risk of exposure to tuberculosis a single dose of BCG vaccine should be given to all infants.	➢ Chronic hepatitis B infection occurs in up to 90% of infants infected with hepatitis B at birth or in the first year of life. Perinatal transmission risk is substantial if the mother is hepatitis B surface antigen (HBsAg) positive. ➢ Hepatitis B vaccine alone is 75% to 95% effective in preventing perinatal hepatitis B transmission when given within 24 hours of birth (ref 31, 31, 32) ➢ The birth dose of hepatitis B vaccine is a critical safety net to protect infants born to hepatitis B–infected mothers not identified at the time of birth. The birth dose can prevent infection of infants born to infected mothers in situations in which the mother's results are never obtained, are misinterpreted, are falsely negative, are transcribed or reported to the infant care team inaccurately, or simply not communicated to the nursery (ref 29) ➢ The risk of HBV infection for infants born to HBsAg-positive mothers increased significantly when the first dose of hepatitis B vaccine was received after 7 days compared with	30. WHO recommendations on newborn health approved or under review by the WHO Guidelines Review Committee 2013 WHO. Page 5 31. AAP COMMITTEE ON INFECTIOUS DISEASES and AAP COMMITTEE ON FETUS AND NEWBORN. Elimination of Perinatal Hepatitis B: Providing the First Vaccine Dose Within 24 Hours of Birth. Pediatrics. 2017;140(3): e20171870. 32. Lee C, Gong Y, Brok J, Boxall EH, Gluud C. Effect of hepatitis B immunisation in newborn infants of mothers positive for hepatitis B surface antigen: systematic review and meta-analysis. BMJ. 2006;332(7537):328–336

Key Practices	WHO Recommendations	Evidence	References
		those vaccinated on days 1-3 following birth (ref 29)	
Companion of choice at delivery	Continuous companionship during labour is recommended for improving labour outcomes (WHO maternal health guidelines currently being finalized)	➢ Women with continuous labor support are *more* likely to have (ref 33,34): - Spontaneous vaginal births (with neither vacuum extraction nor forceps) - Shorter labors ➢ Women with continuous labor support are *less* likely to have (ref 33,34): -A negative birth experience -Pain medication while giving birth -Regional pain medication (e.g. epidural or spinal) -An instrumental vaginal birth (with vacuum extraction or forceps) -A low 5-minute Apgar score -A cesarean birth	33. National Partnership for women and children. Continuous Support for Women During Childbirth: 2017 Cochrane Review Update Key Takeaways July 2017 34. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6
No fundal pressure during delivery	Fundal pressure is not recommended for improving labour outcomes (WHO maternal health guidelines currently being finalized)	➢ There is no evidence that fundal pressure, either manually or by inflatable belt improves outcomes for mother or baby for any delivery; nor is there evidence that fundal pressure worsens outcomes (ref 35) ➢ No benefits noted for reducing: time of labour, instrumental births, caesarean births, operative births, duration of second stage, low arterial cord pH, Apgar scores less than seven at five minutes, cervical tears. ➢ Third degree perineal tears were increased in the inflatable belt group	35. Hofmeyr GJ, Vogel JP, Cuthbert A, Singata M. Fundal pressure during the second stage of labour. Cochrane Database of Systematic Reviews 2017, Issue 3. Art. No.: CD006067. DOI: 10.1002/14651858.CD006067.pub3.

Key Practices	WHO Recommendations	Evidence	References
Induction of labour	See WHO Guidelines (36) Induction of labour is recommended for women who are known with certainty to have reached 41 weeks (>40 weeks + 7 days) of gestation. Induction of labour is NOT recommended in women with an uncomplicated pregnancy at gestational age < 41 weeks. Induction of labour is recommended for women with pre-labour rupture of membranes at term. Oral misoprostol (25 µg, 2-hourly) or low-dose vaginal misoprostol (25 µg, 6-hourly) is recommended for induction of labour. If prostaglandins are not available, intravenous oxytocin alone should be used for induction of labour.	Compared with placebo or expectant management, the use of oxytocin alone was associated with fewer vaginal births not achieved within 24 hours of induction of labour (three trials, 399 participants, RR 0.16, 95% CI 0.1–0.25), fewer admissions to a neonatal intensive care unit (seven trials, 4387 participants, RR 0.79, 95% CI 0.68–0.92), and increased risk of caesarean section (24 trials, 6620 participants, RR 1.17, 95% CI 1.01–1.35) (EB Table 2.1.1).	36. WHO recommendations on maternal and perinatal health approved by the WHO Guidelines Review Committee 2013 WHO. Page 4-5 37. WHO Guidelines for Induction of labour, WHO: 2012

Key Practices	WHO Recommendations	Evidence	References
	Amniotomy alone is NOT recommended for induction of labour		
Augmentation of labour	See WHO Guidelines (36) The use of oxytocin for treatment of delay in labour is recommended. The use of oral misoprostol for labour augmentation is **NOT** recommended. Augmentation with intravenous oxytocin <u>prior to confirmation</u> of delay in labour is **NOT** recommended	There is insufficient evidence support oxytocin augmentation for delayed labour, in spite of its widespread use. The ability of oxytocin to stimulate uterine contractions is undisputed and judicious oxytocin use in case of insufficient contractions can prevent unduly prolonged labour. *IV oxytocin versus no treatment:* ➢ No significant differences for caesarean section, instrumental vaginal birth, low apgar score at 5 minutes *Oral misoprostol for augmenting labour:* ➢ NO clear evidence that the potential benefits of oral misoprostol, compared to intravenous oxytocin, for labour augmentation outweigh its potential harms. *Early versus delayed use of oxytocin for treatment of slow progress in the first stage of labour* ➢ Shorter interval between treatment randomization and birth; but more likely to have uterine hyperstimulation with fetal heart rate changes	38. WHO Guidelines for Augmentation of labour ,WHO: 2014

Key Practices	WHO Recommendations	Evidence	References
		➢ No difference - caesarean section rate, instrumental vaginal births, epidural analgesia, low apgar scores at 5m, or admission to NICU	